TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Ahmed Khalifa, M.D.

**Respondent Name**
El Paso Water Utilities

**MFDR Tracking Number**
M4-15-3327-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
June 8, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We submitted a request for reconsideration to Claims Administrative Services on February 27, 2015. This request was in response to a $300.00 reducation of the $1,400.00 for the DDE performed on December 17, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

**Amount in Dispute:** $300.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The medical bill attached reflects only 4 body areas. Payment was issued based on MMI, plus 4 body areas. We maintain our payment in the amount of $1100.00 is correct based on the medical bill we have received and that no further reimbursement is due."

**Response Submitted by:** Claims Administrative Services, Inc.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 17, 2014 | Designated Doctor Examination (MMI/IR) | $300.00 | $150.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing medical bills.
3. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 0790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - Notes: "THE BILLING WE HAVE RECEIVED ONLY DOCUMENTS 2 MUSCULOSKELETAL BODY AREAS AND 2 NON MUSCULOSKELTAL AREAS. WE HAVE ALLOWED $350.00 FOR MMI, $300.00 FOR 1ST MUSCULOSKELETAL BODY AREA AND $150.00 FOR EACH AREA THEREAFTER FOR A TOTAL OF $1100.00. THE MEDICAL BILL DOES NOT DOCUMENT 6 BODY AREAS. PLEASE ADVISE THE ADDITIONAL PAYMENT BEING REQUESTED AND HOW THIS DETERMINATION WAS ARRIVED AT."

**Issues**

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that

   > (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows… (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area. (D) …(i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides… (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

   Review of the submitted documentation finds that the requestor billed for 6 units for Impairment Rating in accordance with 28 Texas Administrative Code §134.204 (j)(4)(A). The *AMA Guides to the Evaluation of Permanent Impairment* (fourth edition) states that documentation should be written in such a way that "any knowledgeable person can compare the clinical findings with the *Guides* criteria and determine whether or not the impairment estimates reflect those criteria" (p. 2/8). The narrative provides clear support for impairment ratings of one musculoskeletal body area with full physical evaluation and range of motion, one additional musculoskeletal body area, and three non-musculoskeletal body areas. Therefore, the total MAR for the examination to determine Impairment Rating is $900.00.

2. The total MAR for the disputed services is $1250.00. The insurance carrier paid $1100.00. Therefore, an additional reimbursement of $150.00 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | August 14, 2015 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.